BEFORE THE APPEALS BOARD
FOR THE
KANSAS DIVISION OF WORKERS COMPENSATION

HONG VAN NGUYEN	)	
Claimant	)	
VS.	)	
	)	Docket No. 176,235
IBP, INC.	)	
Respondent	)	
Self-Insured	)	

ORDER

This case comes before the Appeals Board on remand from the Kansas Supreme Court. Oral argument was held by telephone conference. Mr. Jeffery K. Cooper was appointed Member Pro Tem to serve in place of Appeals Board Member Gary M. Korte, who recused himself from this proceeding.

APPEARANCES

Claimant appeared by and through his attorney, Diane F. Barger of Wichita, Kansas. Respondent, a qualified self-insured, appeared by and through its attorney, Jennifer Hoelker of Dakota City, Nebraska.

RECORD AND STIPULATIONS

The Appeals Board has consider the record and has adopted the stipulations listed in the Award.

ISSUES

Special Administrative Law Judge Michael T. Harris entered the Award in this case on July 29, 1996. The claimant filed his application for review of the award with the Division of Workers Compensation on September 9, 1996. Clearly in excess of the 10 days allowed by K.S.A. 1996 Supp. 44-551(b)(1). The claimant filed an affidavit with his application for review stating that because of an error made by the Administrative Law Judge in the address of claimant's attorney she did not receive the Award until September 6, 1996. Because the Workers Compensation Act does not permit the extension of the appeal time upon a party showing excusable neglect based upon failure

to learn of the entry of judgement, the Appeals Board concluded that claimant's application for review was filed out of time and it did not have jurisdiction to review the Award.

The Kansas Supreme Court reversed the Appeals Board Order finding the incorrect address resulted in claimant receiving the Award well after the statutory time for filing an appeal. The claimant, therefore, did not have notice of the decision and was denied the opportunity to appeal the Award. The Court found this was denial of due process and the Appeals Board's dismissal of the case should therefore be reversed and remanded to the Appeals Board for further proceedings.[1]

Accordingly, the Appeals Board, on remand, will now address the issues raised by the parties from claimant's appeal of the Special Administrative Law Judge's July 29, 1996, Award. The Special Administrative Law Judge's Award limited claimant to a 25 percent permanent partial disability for a scheduled left forearm injury.[2] Claimant requested the Appeals Board review the Award contending that he proved he sustained a work-related whole body permanent functional impairment and was entitled to permanent partial disability benefits based on a work disability. Additionally, claimant argued his average weekly wage was higher than found by the Special Administrative Law Judge because the average weekly wage should have been computed on a six-day work week instead of a five-day work week.

In contrast, the respondent contended that the deposition testimony of James P. McHugh, Ph.D., should not be considered part of the evidentiary record because the deposition was taken after claimant's terminal date expired. Further, respondent contended claimant failed to prove he suffered a work-related injury. But if the Appeals Board finds claimant's injury was work related, then claimant failed to prove that he suffered any permanent functional impairment as a result of the injury. Also, respondent contended the Special Administrative Law Judge erred in awarding claimant future medical treatment upon proper application and approval of the Director.

In summary, the issues for Appeals Board review on appeal are:

(1) Should the deposition testimony of James P. McHugh, Ph.D., be considered part of the evidentiary record?

(2) Did claimant suffer an accidental injury that arose out of and in the course of his employment?

(3) What is the nature and extent of claimant's disability?

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[1] *See* Nguyen v. IBP, Inc., 266 Kan. 580, 972 P.2d 747 (1999).

[2] *See* K.S.A. 1992 Supp. 44-510d(a)(12).

(4) What is claimant's average weekly wage?

(5) Is claimant entitled to future medical treatment upon proper application and approval of the Director?

FINDINGS OF FACT AND CONCLUSIONS OF LAW

After reviewing the record and hearing the arguments of the parties, the Appeals Board, for the reasons stated below, finds that the Special Administrative Law Judge's Award should be affirmed for all issues except for the issue regarding the admissibility of Dr. James P. McHugh's deposition testimony.

(1) The Special Administrative Law Judge, without further comment, overruled respondent's objection to the deposition testimony of James P. McHugh, Ph.D. Claimant took Dr. McHugh's deposition on October 11, 1995. Dr. McHugh, a clinical psychologist, at the request of Lynn D. Ketchum, M.D., had interviewed and evaluated claimant on October 13, 1993. The Administrative Law Judge set claimant's terminal date for the presentation of evidence for August 1, 1995. Without requesting an extension of that terminal date, claimant scheduled Dr. McHugh's deposition for October 11, 1995. Claimant argues that Dr. McHugh's testimony was necessary rebuttable testimony to Bruce D. Geller's, M.D., testimony that was taken by the respondent on September 15, 1995.

When claimant scheduled Dr. McHugh's deposition, after the expiration of his terminal date, on October 4, 1995, respondent filed a Motion to Quash Deposition. The Administrative Law Judge, who was assigned this case, did not have an opportunity to hold a hearing on the motion before the October 11, 1995, deposition date. Therefore, at the deposition, the respondent objected to the taking of the deposition because it was being taken outside the claimant's terminal date. The Administrative Law Judge never did hold a hearing on respondent's objection. But respondent, in its submission letter to the Administrative Law Judge, again raised the objection for determination in the final Award. The Special Administrative Law Judge who decided the case was not the Administrative Law Judge who set the terminal dates or presided over the trial of the matter.

An administrative law judge is required to set terminal dates for all parties after the first full hearing on the case. Extensions of terminal dates may be granted, if all parties agree, for certain situations where a medical evaluation of the claimant is unable to be obtained before the submission of the case, or for good cause shown.[3]

In this case, claimant did not request an extension of his terminal date. Instead, claimant simply scheduled Dr. McHugh's deposition, labeling the deposition as rebuttal evidence. Claimant likewise did not seek leave of the court to take rebuttal testimony.

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[3]K.S.A. 44-523(b).

Dr. McHugh interviewed and tested the claimant on October 13, 1993, and submitted a psychological evaluation report on the same date. Bruce D. Geller, M.D., at the request of orthopedic surgeon Lowry Jones, Jr., M.D., on October 18, 1994, examined claimant and issued a report on the same day. The parties stipulated into evidence Dr. Geller's report on May 1, 1995. But the record does not contain a stipulation admitting Dr. McHugh's report into evidence. The claimant, however, had knowledge of both Dr. Geller's and Dr. McHugh's findings before his terminal date expired on August 1, 1995. Thus, the claimant had the opportunity to take Dr. McHugh's deposition testimony before his terminal date expired or at least to request the extension of the terminal date and failed to do so.

The Appeals Board concludes respondent's objection to the deposition testimony of Dr. McHugh taken by claimant after his terminal date had expired should be sustained. Claimant has made an argument that Dr. McHugh's testimony was necessary testimony to rebut the testimony of Dr. Geller. But the Appeals Board finds claimant had knowledge of both Dr. McHugh's and Dr. Geller's findings and conclusions before his terminal date expired. If claimant wanted to take the deposition of Dr. McHugh, he should have either taken it before his terminal date expired or requested an extension of the terminal date. The Administrative Law Judge is required to set terminal dates and extensions should not be granted unless the party requesting the extension meets one of the conditions set forth in the statute.[4] In this case, claimant failed to take the deposition before his terminal date expired and also failed to request an extension of his terminal date. Good cause was never shown. The objection to the admission of Dr. McHugh's testimony is, therefore, sustained. The Appeals Board will not consider the testimony for this review and Order.

(2) The Special Administrative Law Judge found claimant suffered a left forearm injury while employed by the respondent. The respondent argues claimant failed to prove the left forearm injury is work related. In contrast, claimant contends he proved he suffered not only an injury to his left forearm but also a permanent injury to his left shoulder and is entitled to a whole body disability. The Appeals Board agrees with the Special Administrative Law Judge and finds the record supports the conclusion that claimant suffered only a left a forearm injury while employed by the respondent.

Claimant started working for the respondent on June 22, 1992. His job was to trim meat from neck and back bones with an electric knife. Claimant was left hand dominant and started having symptoms in the left hand as he continued to do the repetitive work of trimming the bones. Claimant first notified his supervisor of the pain and discomfort in his left hand on November 6, 1992. He was sent to the company's dispensary on that date. The November 6, 1992, dispensary note was admitted into evidence by stipulation and indicated claimant complained of a locking right ring finger and left middle finger. This is

[4]K.S.A. 44-523(b).

the only time a medical record indicates claimant made a complaint in regard to his right fingers. Claimant's fingers were splinted and claimant was told not to do any tight gripping.

Claimant returned to the dispensary on November 13, 1992, and was seen at that time by the company physician, Edward G. Campbell, M.D. The doctor instructed the claimant to continue to wear the finger splints. Dr. Campbell next saw claimant in the dispensary on November 19, 1992. At that time, claimant had some left shoulder complaints. The doctor continued claimant with splints on his fingers and referred claimant to physical therapy for his left shoulder complaints. Claimant returned to the dispensary on December 3, 1992, and Dr. Campbell diagnosed claimant with tenosynovitis. Since claimant remained symptomatic, he was referred to a local orthopedic surgeon, Michael Montgomery, M.D.

Before claimant saw Dr. Montgomery, he had six physical therapy treatment sessions for his left shoulder. A physical therapy note dated December 3, 1992, was admitted into evidence by stipulation. The physical therapist noted that claimant was initially presented with a very limited range of motion and intense pain in his left shoulder. But after six physical therapy sessions his left shoulder range of motion was nearly normal, and he had very little pain.

Dr. Montgomery saw claimant once on December 14, 1992. Dr. Montgomery's medical note indicated claimant was examined for a left hand injury with tenderness and stiffness in his left fingers. The note did not contain any left shoulder complaints. Dr. Montgomery recommended that claimant be referred to a hand specialist for his left hand and finger problems.

Claimant was then seen by hand surgeon John B. Moore, IV, M.D. He first saw the claimant on January 19, 1993. After Dr. Moore examined claimant, he referred him for an EMG and nerve conduction study that indicated minimal slowing in the distal ulnar nerve but no involvement at the median nerve. But Dr. Moore found, anatomically, that this minimal distal ulnar nerve slowing had nothing to do with claimant's present complaints of pain, numbness, and complete stiffness of his left ring and long fingers. Dr. Moore was suspicious that the original problem was trigger finger in the left long and ring fingers. Because of the pain, claimant refused to flex the fingers. Accordingly, claimant had been holding the fingers in a stiff extended position for almost five months that had resulted in painfully stiff fingers. Dr. Moore referred claimant to physical therapy for exercises in an effort to provide movement to the fingers.

Dr. Moore also ordered a repeat EMG study on April 13, 1993. This study was normal. The doctor concluded there was no physical reason claimant could not move his fingers. Dr. Moore opined, by the process of exclusion, that the only explanation for claimant's abnormal condition was hysterical paralysis. He released claimant from his care and although claimant had almost total impairment of the left hand, Dr. Moore opined the injury was not caused by work but was a psychological reaction.

Next, claimant was seen by Lynn D. Ketchum, M.D., on June 23, 1993. Dr. Ketchum found claimant able to flex and extend his left thumb. But claimant indicated to Dr. Ketchum he no longer had any feeling in the digits of his left hand. Dr. Ketchum agreed with Dr. Moore that claimant's problems originally likely started from tenosynovitis of the fingers. The fingers were then splinted with all of them ending up stiff. The doctor felt claimant could be helped by surgery. But he would not consent to perform surgery until claimant was evaluated by a psychologist to rule out hysterical paralysis or conversion reaction. He recommended that claimant be interviewed and tested by clinical psychologist James P. McHugh, Ph.D.

Claimant was evaluated by Dr. McHugh on October 13, 1993, and his findings are contained in a report dated the same date. But Dr. McHugh's evaluation report was not stipulated into the record, and the Appeals Board has previously ruled that his deposition testimony is not admissible because claimant took the testimony after his terminal date expired.

Another orthopedic surgeon, Lowry Jones, Jr., M.D., saw claimant at the request of the respondent on January 11, 1994. He found claimant with stiff and sore left fingers. He referred claimant for another neurological evaluation and EMG testing. After he reviewed the EMG study and the neurological evaluation, Dr. Jones opined claimant did not have any organic orthopedic problems he could identify. Additionally, he concluded there were no findings consistent with a work-related injury while employed by the respondent. Dr. Jones felt claimant's problems were psychogenic. Also, the doctor could not relate the psychogenic problems to any work-related injury.

At the request of claimant's attorney, he was examined and evaluated by orthopedic surgeon Nathan Shechter, M.D. The doctor saw claimant on one occasion, September 9, 1994. He found claimant with complaints of constant left hand pain, restrictive motion of all fingers on the left hand except the thumb, and lack of mobility in the entire left upper extremity. There was marked restriction of left shoulder motion in all directions. Claimant resisted any flexion of the left fingers complaining of severe pain.

Dr. Shechter also felt claimant's original problems were likely due to a "stenosing tenosynovitis" of the left fingers. Because of the pain, claimant's fingers were splinted resulting in stiffness. The doctor found that claimant had developed marked restriction of motion of the left shoulder and an adhesive pericapsulitis of the shoulder. This restrictive motion in the left shoulder was complicated because of claimant's voluntary restriction of the motion due to pain and a great deal of functional overlay. Dr. Shechter thought claimant was a candidate for left hand surgery which would help with the stiffness of the fingers. He assessed claimant with a 60 percent permanent functional impairment of the left upper extremity or a 36 percent functional impairment of the whole body. The doctor found claimant should not return to the work he was performing for the respondent. Further, he restricted claimant from lifting more than 10 pounds and no overhead work with the left upper extremity.

Because claimant had been examined, evaluated, and treated by numerous physicians and those physicians had various opinions concerning claimant's injuries, the Administrative Law Judge appointed orthopedic surgeon Fred M. Wood, M.D., and psychiatrist Harold M. Voth, M.D., to perform independent medical examinations of claimant. Dr. Wood is, in addition to an orthopedic surgeon, a specialist in hand surgery. His deposition testimony was not taken but his medical reports were stipulated into evidence by the parties.

Dr. Wood saw claimant for the first time on March 1, 1995. The doctor found claimant with complaints of pain mainly in the left hand and numbness in his left long, ring, and small fingers. Dr. Wood also felt it was probable that claimant first developed constrictive tenosynovitis of the left long and ring fingers. On examination the doctor found claimant to have a rigid little finger and the long and ring fingers were maintained in the slight swan neck type position. The middle upper joints flexed fairly well, and claimant's left thumb appear to be not severely affected. But his left shoulder was difficult to evaluate because claimant would not move the shoulder voluntarily. No atrophy was found in claimant's forearm or upper arm. At the conclusion of the examination, Dr. Wood felt claimant had developed a hysterical reaction as a result of the left hand injury plus the claimant had signs of chronic ulnar nerve entrapment at the wrist and the elbow.

Dr. Wood saw claimant again on March 3, 1995. At that time, he measured the distal motor latency across the left nerve at the wrist. He found the latency to be slightly elevated. His final diagnosis was compression of the ulnar nerve at the wrist and chronic stenosis of a constrictive nature in the ulnar nerve of three digits of the left hand. Dr. Wood recommended surgical decompression of the nerve at the wrist and the release of the constrictions at the A1 pulleys and maybe perform tenolysis as well.

After claimant elected not to have surgery, Dr. Wood opined that claimant's work activities while employed by the respondent contributed to claimant's tendonitis problem, ulnar nerve entrapment, and tenosynovitis of flexor tendons of the small, ring, and long fingers of the left hand. But Dr. Wood did not find any evidence that claimant's hysteria or left shoulder pain was caused or contributed to by claimant's work. Dr. Wood's opinion on permanent functional impairment was 20 to 30 percent of the left upper extremity or 12 to 18 percent of the whole body. He placed restrictions on claimant's work activities for the left upper extremity of no functions above shoulder level and limited tasks with the left hand to simple pinching or minimal grasping of the left thumb and index finger.

Neurologist Bruce D. Geller, M.D., saw claimant on October 18, 1994, at the request of Dr. Lowry Jones. Dr. Geller's deposition testimony was taken by the respondent. After an extensive examination of claimant, Dr. Geller found claimant to be a faker and a malinger. He found no objective evidence of any neurological disorder, damage, or disfunction causing weakness or damage to claimant's left upper extremity.

Psychiatrist Harold M. Voth, M.D., performed a independent medical examination of claimant in relation to the malinger issue. Dr. Voth saw claimant on March 2, 1995. The doctor examined claimant's left hand and found the fingers extended and stiff. Claimant winched in an exaggerated fashion when the fingers were even slightly touched or attempted to be flexed. Dr. Voth concluded claimant was unconsciously exaggerating his symptoms but was not an outright malinger.

At the regular hearing on April 7, 1995, claimant testified his left hand, arm, and shoulder had worsen since he had last worked for the respondent. Respondent terminated claimant on or about March 2, 1993, for missing a physical therapy session. Claimant testified he had not worked since the termination and was currently receiving Social Security Disability benefits. Claimant testified he essentially had no use of his left upper extremity. Any daily living activities that had to be performed with his upper extremity were performed utilizing his non-dominant right upper extremity. Claimant relied on friends to fix his meals and to perform other essential tasks such as his laundry needs.

Respondent argues claimant has failed to prove he suffered a permanent injury to his left hand while employed by the respondent. Respondent specifically points to the opinions of Dr. Moore and Dr. Jones that there is no orthopedic or physical reason for claimant's left hand problems and they found there was no evidence to support a work-related injury. Further, Dr. Geller, after conducting an extensive examination of claimant, found claimant was faker and a malinger. Additionally, he found there was no neurological findings to support a left hand injury.

The record contains divergent and conflicting opinions between the various physicians who either treated or examined claimant for his alleged upper extremity injury. The Appeals Board finds the most persuasive and credible medical opinion contained in the record is that of Dr. Wood who was appointed to perform an independent medical examination of claimant. When Dr. Wood's opinions are coupled with the claimant's testimony, the Appeals Board concludes claimant has proved that his work activities while he was employed by the respondent caused injury to his left upper extremity.

(3) As to the nature and extent of claimant's injury to his left upper extremity, the claimant contends the greater weight of the evidence in the record proves the injury extended to claimant's left shoulder and is, therefore, a whole body injury under the law in the effect at that time. Accordingly, claimant further argues the record proves he is entitled to a 100 percent work disability because his work-related injury has resulted in a 100 percent loss of ability to perform and to earn wages in the open labor market.[5]

In contrast, respondent argues, if the Appeals Board determines claimant has suffered a work-related injury, then that injury is limited to a scheduled injury to claimant's

[5]*See* K.S.A. 1992 Supp. 44-510e(a).

left hand.[6] Because claimant injury is not a whole body injury, then claimant is not entitled to permanent partial disability benefits based on a work disability.

The Appeals Board acknowledges that claimant had left shoulder complaints along with left finger complaints in November of 1992. Also, the Appeals Board acknowledges claimant received treatment through physical therapy for left shoulder pain from November 20, 1992, to December 3, 1992. But the physical therapy notes indicate the physical therapy treatment was successful because claimant's left shoulder range of motion was normal. Furthermore, he had very little pain after these treatments. The Appeals Board finds there is no evidence that claimant made additional complaints of left shoulder problems or was treated for left shoulder problems by either Dr. Moore, Dr Ketchum, or Dr. Jones.

The records reflect claimant did complain to Dr. Wood and Dr. Shechter about extreme left shoulder problems at the time of their examinations. But Dr. Wood found claimant would not voluntarily move the left shoulder and there were no objective findings to support the non-movement or the extreme pain claimant exhibited in the left shoulder. In Dr. Wood's letter dated September 25, 1995, he opined that there was no evidence that claimant's hysteria or his left shoulder pain were caused or contributed by claimant's work. Furthermore, because Dr. Wood's deposition was not taken, it is impossible to determine what, if any portion of his left upper extremity impairment rating of 20 to 30 percent is attributable to a left shoulder injury.

The Appeals Board concludes the claimant has not proved that any of the 20 to 30 percent permanent functional impairment rating as imposed by Dr. Wood is related to claimant's left shoulder complaints. Based on the record, the more plausible conclusion is that Dr. Wood's rating is related to claimant's stiff fingers and ulnar nerve entrapment and does not include the left shoulder. The Appeals Board, therefore, finds the record as a whole supports the Special Administrative Law Judge's finding that claimant suffered a permanent work-related injury to his left forearm and did not suffer a whole body injury.

(4) The Special Administrative Law Judge found claimant's average weekly wage was $326.83 based on claimant's earnings record admitted into evidence at the regular hearing. But claimant argues his average weekly wage should be computed based on a six-day work week instead of a five-day work week which would then equal $440.91.[7]

Claimant testified he was expected to be available to work on Saturdays and did work on Saturdays when respondent needed him. But the earnings record indicates claimant only worked eight hours of overtime during four weeks of the 26 weeks reported

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[6] *See* K.S.A. 1992 Supp. 44-510d(a)(11).

[7] *See* Tovar v. IBP, Inc., 15 Kan. App. 2d 782, 817 P.2d 212, *rev. denied* 249 Kan. 778 (1991).

in the earnings record. The earnings record does not identify whether those overtime hours were worked on Saturdays or whether they were worked during the week. The earnings record also does not indicate the amount of straight time hours that were worked by the claimant during any of the 26 weeks reported.

The Appeals Board concludes that claimant's testimony and the earnings record admitted into evidence at the regular hearing fails to prove claimant was expected to work six days per week. His testimony does prove that he was expected to work on Saturdays when scheduled, but it does not prove he was expected to work six days per week.

(5) The Special Administrative Law Judge found claimant was entitled to future medical treatment for his work-related injuries upon proper application and approval of the Director. The respondent argues claimant is not entitled to future medical treatment because the evidence in the record indicates he was released from medical treatment after he had meet maximum medical improvement. Therefore, respondent argues there is no evidence in the record of claimant's need for future medical treatment.

The Workers Compensation Act requires the respondent to provide medical treatment as may be reasonably necessary to cure and relieve the claimant from the effects of the injury.[8] Accordingly, the Appeals Board concludes because injuries can and do worsen for various reasons, it is appropriate to award future medical treatment for a worker's injury upon proper application and approval of the Director.

AWARD

WHEREFORE, it is the finding, decision, and order of the Appeals Board that Special Administrative Law Judge Michael T. Harris' July 29, 1996, Award should be, and is hereby, affirmed, except that Dr. James McHugh's deposition testimony is not admitted as evidence in this case.

All remaining orders contained in the Award are adopted by the Appeals Board that are not inconsistent with this Order.

IT IS SO ORDERED.

Dated this ____ day of January 2000.

BOARD MEMBER PRO TEM

[8] *See* K.S.A. 1992 Supp. 44-510(a)

BOARD MEMBER

BOARD MEMBER

c: Diane F. Barger, Wichita, KS
Jennifer Hoelker, Dakota City, NE
Brad E. Avery, Administrative Law Judge
Philip S. Harness, Director